
Management of alcohol misuse within the context of general psychiatry

Duncan Raistrick

The general psychiatrist and the addiction specialist have a shared agenda of concerns and interests about the misuse of alcohol. The task of this paper is to highlight and develop thoughts on items for inclusion on the shared agenda, rather than to define, or limit in any other way, how the generalist role might unfold in a particular place at a particular time. It is certain that the general psychiatrist will see a role that is more than just signposting their own specialist colleagues, local counselling services, or self-help groups such as Alcoholics Anonymous, but opinion on just how broad that role could or should be will vary considerably. One point of difference may be a mismatch of views as to where patients with alcohol misuse problems are best treated: the general psychiatrist seeing alcohol misuse, or even dependence, as having little to do with general psychiatry and belonging within a specialist service, the specialist seeing alcohol misuse as very much part of the every day work of the general psychiatrist. Happily both positions can be correct, but not totally and not without dialogue.

Alcohol misuse is everyone's business: the politician, the publican, the parent, the tax payer, the doctor, the list could go on. A shared agenda, possibly informing the content of journal clubs or case conferences, needs to invoke some passion and to promise benefits for psychiatry. The agenda might include:

- (a) Raising awareness of alcohol misuse within the profession
- (b) Achieving *Health of the Nation* targets
- (c) Understanding brief interventions for alcohol misuse
- (d) Managing dual diagnosis patients

Whether they are aware of the fact or not, general psychiatrists see many patients whose problems

include alcohol misuse. In the most recent survey of drinking patterns in the general population, Thomas *et al* (1994) found 27% of men and 11% of women drinking above low-risk levels (21 units per week for men and 14 units per week for women), with 8% of men and 1% of women drinking at high-risk levels (51+ units and 36+ units). In a health district of 300 000 this would equate to between 13 000 and 57 000 people misusing alcohol, depending upon the cut-off point which is selected. Even if only 10% of these people are seeking help or find themselves in hospital or out-patient services for reasons other than alcohol misuse at any given time, it would be ludicrous to think that such numbers could be handled by the resources of an addiction team, even if this were considered a good idea. Some 20% of patients in general medical wards, and rather greater numbers in psychiatric wards, have alcohol related problems (although these are not necessarily the cause of admission), but 20% of doctors are not addiction specialists, and no-one would think it sensible to create such numbers. So, the inescapable implication of these figures is that people who misuse alcohol will be a challenge to all doctors in their day-to-day practice.

Raising awareness

The medical profession has steadily reduced its *per capita* intake of alcohol over the last 10–20 years and come to see drinking as incompatible with the workplace. Medical students and doctors now have similar consumption levels, when matched by age and gender, to the general population, having in the past had much higher levels. This should not

Duncan Raistrick is the Clinical Director of both the Leeds Addiction Unit and the Yorkshire Addiction, Research, Training and Information Consortium. He is a member of the Executive Committee of the Society for the Study of Addiction and a member of advisory committees to charitable and government agencies.

be taken as a reason for complacency as the reduction in alcohol related problems among doctors is only down to the levels of alcohol related harm in the general population, which remain high. It is to be expected that social trends will be reflected in the behaviour of medical students and young doctors. In a study comparing lifestyles of Newcastle medical students in 1983–84 with 1993–94, Ashton & Kamali (1995) found a modest increase in alcohol consumption between the two periods, with 32% of men and 21% of women drinking above low-risk levels: 94% gave 'pleasure', and 9% 'exam pressures' as reasons for drinking. There was an increase in those who had 'ever used' cannabis from 26% to 54% for men and 15% to 46% for women, and an increase for both groups from 3% to 22% for having 'ever used' other illicit drugs. These findings are not confined to Newcastle, nor to medical students, indeed medical students compare favourably to other students.

Clearly progress has been made on raising awareness of alcohol misuse within the profession. Nonetheless, situations involving alcohol or other drugs still contributed 31 of 55 cases entering the General Medical Council health procedures in 1994, and only three doctors in the last year were successfully returned to practice. In a retrospective casenote study of 144 doctors with substance misuse problems, Brooke (1995) identified stress of work or of life events coupled with a vulnerable personality, usually characterised by traits such as anxiety, introversion or obsessionality, to be frequent companions of substance misuse. Other risk factors are isolation and collusion by family, friends and colleagues with the net result that intervention often comes too late. On the positive side, doctors have the potential to mobilise powerful protective mechanisms through their knowledge base, peer support and formal professional support.

From the point of view of self-awareness and patient care, the effects of alcohol and other psychoactive drugs on health need to be discussed throughout medical training. Psychiatrists as a group have traditionally led the call for alcohol education in the medical curriculum (Ritson, 1990). A failure to permeate alcohol education into the new medical curricula will be to neglect a responsibility of the profession to trainee doctors and their patients. It is equally important that awareness is maintained as part of continuing education. Consultants can set the clinical standard by rigorously accounting for the contribution of alcohol to physical and mental illness in their routine practice. In addition, consultants in psychiatry share a special role within the health care community, namely to engender good mental

health. Alcohol misuse will be one of the more common barriers to achieving this goal.

Understanding dependence

Tober (1992) theorises on the meaning of dependence and concludes that dependence is important because it is the essence of addiction. The arguments underpinning this deceptively obvious conclusion are more complex than might at first be assumed and are not universally accepted. The concept of a dependence syndrome was first described in provisional form by Edwards & Gross (1976) and was incorporated into ICD-9 after approval by the World Health Organization in 1979. The dependence syndrome departed from the notion of 'alcoholism', a disease concept, in two important ways: first, dependence was seen as existing along a continuum of severity, implying the need for different treatments and different outcome goals; second, alcohol related disabilities in the physical, psychological and social spheres were to be seen as belonging to a separate domain. Dependence was described as a biopsychosocial syndrome consisting of seven markers:

- (a) Narrowing of drinking repertoire
- (b) Salience of drink related behaviour
- (c) Increased tolerance to alcohol
- (d) Repeated withdrawal symptoms
- (e) Relief or avoidance of withdrawal symptoms by further drinking
- (f) A subjective awareness of a compulsion to drink
- (g) Rapid reinstatement after a period of abstinence.

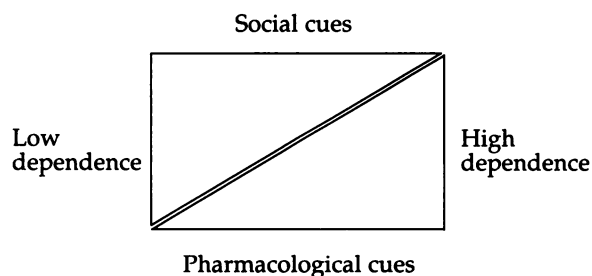
A number of criticisms followed, the most damaging of which was the contention that the dependence syndrome had little predictive validity, limited clinical utility, and that estimates of alcohol intake and patterns of consumption are more helpful (Robertson, 1986). It is true that the largest slice of outcome variance is accounted for by social stability factors, however, it does not follow that dependence is of limited utility. Rather, it follows that social treatments are effective at extinguishing learned behaviour such as dependence. This point is illustrated by Azrin *et al* (1982) who described favourable outcomes using a Community Reinforcement Approach, a comprehensive package of social interventions, to treat alcohol misuse problems. When making treatment decisions, the clinician needs to assess the extent to which dependence is driving continued excessive drinking in order to determine 'how much'

treatment will be needed. As dependence becomes more severe then so social cues for drinking diminish and pharmacological ones come to dominate (see Fig. 1). This does not mean that social therapy is necessarily less effective than cognitive-behavioural or spiritual interventions for more severely dependent patients. The effectiveness of any therapy depends on the extent to which it is able to optimise benefits of cue avoidance, or cue exposure, and reinforce behaviours incompatible with drinking.

The biopsychosocial description of dependence has been further criticised for placing unwarranted emphasis on withdrawal symptoms. While the anticipation or experience of withdrawal may indeed be a potent source of negative reinforcement for drinking it is not the only source of reinforcement, and it may be that the positive reinforcement of a pharmacological (alcohol) effect is more important whether or not an individual also experiences withdrawal.

Room (1989) succinctly captures the political dimension of the debate submitting that "the de-emphasis of cognitive and experiential dimensions in medical definitions and operationalisations of dependence reflects a strong pull towards reductionist and psychological conceptions in medical thought". A consequence has been confusion over the meaning of dependence – some authors continue to distinguish between physical dependence, which seems to be code for medical territory, and psychological dependence, code for psychological territory. In other words, the clinical understanding of tolerance and withdrawal has been lost in a contest for medical or for psychological hegemony. The important end point of this debate is that the terms 'psychological' and 'physical' dependence should be discounted; physical dependence refers to withdrawal symptoms and to tolerance which are best seen as separate phenomena to dependence and referred to collectively as neuroadaptation.

Fig. 1 Relationship between dependence and drinking cues



Raistrick *et al* (1994) have proposed a modified description of the dependence syndrome and developed the idea of substance dependence as a purely psychological phenomenon where tolerance and withdrawal are understood as consequences of regular drinking, rather than being a part of dependence. The withdrawal symptoms themselves are one step removed from the cognitive response to the symptoms, which may or may not include thoughts about drinking. If withdrawal symptoms were themselves a defining element of dependence then different drugs would be associated with different kinds of dependence, but this is not a widely held view, rather it is believed that dependence can readily shift from one substance to another (Kosten *et al*, 1987). The markers of substance dependence translate the neuroadaptive elements of the biopsychosocial description of dependence into cues which condition cognitions and behaviours and are therefore of more universal application. There are ten markers of substance dependence:

- (a) Preoccupation with drinking or taking drugs
- (b) Salience of substance use behaviour
- (c) Compulsion to start using drink or drugs
- (d) Planning drink or drug related behaviours
- (e) Maximising the substance effect
- (f) Narrowing of substance use repertoire
- (g) Compulsion to continue using drink or drugs
- (h) Primacy of psychoactive effect
- (i) Maintaining a constant state (of intoxication)
- (j) Expectations of need for substance use.

Substance dependence also departs from the broader psychological view of dependence proposed by Orford (1985) which embraces such objects of dependence as people and activities. In many ways this ubiquitous dependence is a restatement of learning theory. What distinguishes substance dependence from other behavioural dependencies, like gambling or exercise, is the way in which addictive drugs alter the physiological substrate upon which they act thereby increasing reinforcement potential. The distinction is imperfect but serves to define boundaries which have found clinical relevance.

The Leeds Dependence Questionnaire (LDQ; Raistrick *et al*, 1994) was derived from the idea of substance dependence and was designed to measure dependence on any psychoactive drug; to date the questionnaire has been validated for use with alcohol and heroin users. The dominant view in the addiction field is that dependence is a learned phenomenon where expectations play a central part: in other words beliefs about, for example, what will happen on taking a drink after a period of abstinence have a greater effect on outcome than

alcohol does itself. How these learned cognitions and behaviours change is not yet understood. Is it the case that dependent behaviour, drinking, can be extinguished, or is it that the behaviour changes as a result of cognitive control resulting in avoidance? Most likely both of these mechanisms can operate. This distinction is an important one in that social drinking, controlled drinking or abstinence from drinking are possible drinking goals, but the appropriate goal will depend upon the degree of extinction that can be achieved.

In summary, dependence is conceptualised in psychological terms and can be assessed by questionnaire or by clinical interview. At lower levels of dependence social cues will be more important than pharmacological cues for drinking, but as dependence increases so this relationship is reversed and dependence becomes more fixed indicating that social or controlled drinking goals are unlikely to be successful (Fig. 1). It follows from this that at low levels of dependence a brief alcohol focused intervention or a social intervention, suitable for use in general psychiatry, are likely to be effective. Brief interventions may be no more than an information leaflet, a drinking diary, or five minutes advice and information which is sensitive to a patient's particular problem, but importantly, with a follow-up session.

Dual diagnosis

The most frequent problem for the general psychiatrist is not the straightforward case of alcohol dependence or misuse but the patient with a dual diagnosis. Penick *et al* (1988) administered a DSM-III compatible diagnostic interview to 241 male 'alcoholics' during an in-patient admission and again at 1 year: 30% were deemed to have one additional psychiatric syndrome, 18% two, and 9% three or more additional syndromes. Depression and antisocial personality were the most common diagnoses. There was some fluidity of diagnostic category between intake and follow-up interview: only 62% of men diagnosed with antisocial personality, 53% with depression and 38% with panic attacks had the same diagnosis at both interviews. Rounsaville *et al* (1987) found alcohol dependence complicating psychopathology to be an unfavourable and robust predictor of outcome. However, the authors suggested that, while a dimensional measure of psychopathology is an independent predictor of outcome, categorical diagnosis brings additional predictive power, for example, alcohol misuse secondary to affective disorder carries a relatively favourable prognosis.

Chappel (1993) has recommended that treatment of dual diagnosis patients should be conducted by one clinical team in one setting; this approach has benefits in terms of simplifying communication between clinical staff and ensuring that the links between substance use and psychiatric disorder are fully investigated and dealt with.

Anxiety

The relationship between alcohol and anxiety is complex and each case requires careful clinical assessment. At a pharmacological level, alcohol has an initial, but short-lived, stimulant effect which is superseded by an anxiolytic effect. The use of alcohol to self-medicate anxiety symptoms has long been recognised. It is less appreciated, especially by patients, that more alcohol does not mean more anxiety relief, but rather chronic alcohol use can itself become a stressor and increase anxiety. In proposing a revised tension reduction hypothesis, Young *et al* (1990) illustrate the interaction of expectations and pharmacology. Their preliminary conclusions, with specific caveats that the effects of gender and high versus low dose alcohol need further elucidation, stress the possible difference between 'normal' and 'patient' populations. 'Socially impaired' individuals are more likely to take on positive expectations of the effects of alcohol but actually perform worse under the influence of alcohol, compared to placebo, while continuing to believe their performance to be enhanced. On the other hand, 'normal' subjects with positive expectations for alcohol in socially stressful situations perform better, subjectively and objectively, but only with the enabling effect of alcohol not placebo.

Estimates of the prevalence of anxiety disorder among patients with an alcohol dependence diagnosis typically fall between 10–30%, while of in-patients who have a primary diagnosis of phobic anxiety only 10% have the secondary diagnosis of alcohol dependence, although half will regularly use alcohol as an anxiolytic. Measurement is a major problem, anxiety symptoms are very common and non-specific, symptoms alone do not make for a diagnosis, and misdiagnosis, particularly of alcohol withdrawal, is likely to occur if assessments are made during an episode of heavy drinking or immediately post-detoxification.

Allan (1995) recommended that patients presenting with anxiety and alcohol dependence should first be detoxified and reassessed after 6 weeks when an expected 10% will be found to have persistent symptoms amounting to an anxiety state. This can then be treated using conventional pharmacological or behavioural methods. She

points out that patients may resist such an approach preferring to deal with their psychological distress first. Clinicians can be more confident about reversing the order of treatment where it can be established that anxiety antedates alcohol misuse or is a specific trigger to drinking.

Depression

Davidson & Ritson (1993) found that many of the complex interactions existing in the relationship between alcohol use and anxiety also apply to alcohol use and depression. At low doses alcohol is generally reported to enhance mood, but at higher doses subjects report dysphoria and an aversion to continued drinking. Tolerance may necessitate an increasing level of alcohol intake in pursuit of a mood altering effect that is in reality no longer achievable. Similar problems to those described for anxiety apply when estimating the prevalence of depression. In hospitalised 'alcoholics' 30–40% are found to be depressed, whereas in community samples less than 5% of 'alcoholics' have both diagnoses.

People who are dependent on alcohol usually succumb to a number of financial, family, health and relationship problems and it is not surprising that many will complain of depression; equally it is not surprising that 80% or more will recover within a few weeks of abstinence without recourse to antidepressant treatment. While abstinence may enforce an acceptance of problems accumulated while drinking and this might be anticipated to increase depression, abstinence is also an opportunity to build self-efficacy and self-esteem, both powerful psychological antidepressants. Pharmacological antidepressants should be avoided unless there is unequivocal evidence of a biological depression of mood.

In studies of successful suicides it is usual to find 20–30% who misuse alcohol, however, the high rates of concurrence of depressive illness and alcohol misuse may exaggerate the influence of one or both factors. Murphy (1992) has identified seven risk factors for suicide in 'alcoholics': depression, suicidal thoughts, poor social support, physical illness, unemployment, living alone and recent interpersonal loss. The risks accumulate over a number of years suggesting that there is scope for preventive social and health care.

Personality disorder

Many patients who have a personality disorder also misuse alcohol and are often poly-drug users. Psychiatrists may be pessimistic about working

with these patients, seeing custody as more appropriate, and yet most criminal justice system workers believe that therapy is better than custody. Patients with a dual diagnosis of personality disorder and substance misuse are frequently referred to addiction units. However, Walker (1992) has described the need to understand the psychopathology of personality disorder and sees the inability of these patients to learn from the past or see into the future, a 'living for the moment' state of mind, as the central feature that informs the treatment plan. Accordingly, he does not suggest assigning people with a personality disorder diagnosis to a particular speciality, but rather to a psychiatrist with character traits to match the disorder. He sees these traits as being: self-confidence, truthfulness, neutral interaction, consistency, self-control and the ability to set limits. Such therapist variables may indeed be helpful in containing some personality problems but they fall short of a specific treatment or solution.

Summary

The key issue here is the ephemeral nature of comorbidity, notably so for anxiety and depression (Schuckit & Monteiro, 1988), pointing to a need for restraint when prescribing for patients with a dual diagnosis. Obvious exceptions are Korsakoff's syndrome (Kopelman, 1995) and other organic brain disorders which are normally the remit of rehabilitation teams, and alcoholic delirium which is typically treated within general medical or liaison psychiatry units. The clinician must, however, remain vigilant for psychiatric disorders, for example obsessional neurosis or manic depressive psychosis, which have been masked or partially treated by alcohol and may become more troublesome in the absence of alcohol.

A repertoire of treatment skills

The diagnosis and measurement of dependence tell the clinician what outcome goals are likely to be successful and how much treatment is needed; alongside this an understanding of motivation informs the kind of treatment needed. The Model of Change described by Prochaska & DiClemente (1984) is a motivational model widely used in the addiction field. The purpose of using the model is twofold: first, to understand what is going on for a patient at a given time, and second, to inform the

choice of interventions (Box 1). People who are not motivated to change their drinking behaviour are said to be at the pre-contemplation stage, which is characterised by denial and rationalisation of drinking and its consequences. There are two strands to treatment strategy at this stage: one is to minimise the harm from drinking without expecting to change the drinking behaviour, for example by prescribing vitamin supplements or by providing shelter, the other is to introduce conflict about the drinking, for example by capitalising upon untoward drink related life events. The temptation is to offer treatments aimed at changing drinking behaviour before the patient is ready to change. In such circumstances the treatment will always fail.

The experience of significant conflict about drinking, for example when drinking and driving is felt to be incompatible with a self-image of being a sensible and responsible person, or when the cost of drinking is causing family hardship, indicates movement into the contemplation stage. At this stage motivational interventions which may involve the use of simple clinical tools, for example the decision matrix, or may draw on more sophisticated skills, for example motivational interviewing (Tober, 1991), are indicated.

The action stage is reached when conflict is resolved and there is a commitment to change. A number of things will have happened at a psychological level: the person will believe that life will be better on stopping or controlling their drinking (positive outcome expectancy), will believe that they are able to change (self-efficacy), and will know how to change (skills learning). Elective detoxification is the most common medical intervention at the action stage and it is also one of the most frequently misused interventions in addiction. Not uncommonly patients who have yet to reach the action stage are offered detoxification, possibly because it gives the doctor a sense of helping and possibly because it colludes with a

Box 2. Prescribing points

Chlordiazepoxide: drug of choice for detoxification
Chlormethiazole: in-patient detoxification if a history of seizures or delirium
Disulfiram: adjunctive therapy in the maintenance stage
Naltrexone: adjunctive therapy in the maintenance stage
Antidepressants: use with caution – assess indications post detox. where possible
Anxiolytics: use with caution – assess indications post detox. where possible
Antipsychotics: check for psychotomimetic drugs using toxicology screen

patient's wish to be seen to be having treatment. Not only is the intervention likely to fail if used in precontemplation, but failure is likely to reduce a patient's self-esteem or confirm their belief that they are 'a hopeless alcoholic'. On an out-patient basis, chlordiazepoxide 40–100 mg in divided doses is the drug of choice for detoxification on the grounds that it is effective, has a low addictive potential, low toxicity when mixed with alcohol, and a unique metabolite on urine screening (Box 2). Chlormethiazole may be used on an in-patient basis when there is a history of seizures or delirium, but patients should not take this drug home because of its addictive potential and toxicity when mixed with alcohol.

The maintenance stage follows from behavioural change, the achievement of abstinence or controlled drinking. Maintenance of behaviour change may be assisted by an alcohol sensitising agent such as disulfiram 200 mg daily (Chick *et al*, 1992) or by reducing craving with naltrexone 50 mg daily (Volpicelli *et al*, 1995). Pharmacological interventions are no more than an adjunct to the main task of achieving lifestyle change. Successful recovery requires that the patient has the confidence and skills to deal with drinking cues. The highest ambition would be to take on new activities, incompatible with drinking but at the same time exciting and enjoyable; for example, rock climbing may suit one person while the next will get a 'buzz' from doing voluntary work. The lowest ambition for lifestyle change would simply be to avoid drinking situations and friends. Attendance at Alcoholics Anonymous is very supportive of this limited goal, but group members are locked into the maintenance stage because of continuing self-definition as an 'alcoholic'.

Box 1. Treatment strategy and stage of change

Precontemplation

Harm reduction measures
 Introduce conflict about drinking

Contemplation

Increase motivation to change

Action

Preparation for behaviour change
 Behaviour change

Maintenance

Relapse prevention

Health of the Nation targets

Safer drinking limits

The *Health of the Nation* targets were cynically received, no doubt because of their political origins. Nonetheless, there is much to recommend pursuit of the targets relating to alcohol misuse. The scientific basis for proposing constraints on *per capita* consumption are detailed in *Alcohol Policy and the Public Good* (Edwards, 1994). Achievement of the *Health of the Nation* target to reduce the proportion of men drinking above low-risk limits to 18% and women to 7% by the year 2005 will require an effort by doctors and many others. What will work and be acceptable to the public generally is everyone 'doing a bit' not a few 'doing a lot'. Doctors are known to be effective communicators of brief health care messages (Heather, 1995). All psychiatrists should ensure that their clinics have suitable alcohol information leaflets available and should rehearse a 4–5 minute, brief intervention that includes an explanation of how alcohol misuse and dependence impair mental health.

Suicide

General psychiatrists will be key players in achieving the target of reducing the overall suicide rates by 15% by the year 2000. Many of the factors associated with suicide in 'alcoholics' are amenable to social care and vigorous pursuit of abstinence treatments. It is likely that a significant reduction in suicide can be achieved if social care resources are available and doctors redouble efforts to identify 'at risk drinkers'.

Referrals to specialists

There can be no hard and fast rules on referral, much will depend upon local agreement and available resources. Ideally a doctor with special knowledge of addiction should be available to general psychiatry colleagues to assess patients and advise on case management. However few addiction teams are able to meet this demand, and as psychiatrists are dispersed into geographically separate community bases and Trusts, even informal discussion becomes more difficult. Patients most likely to be referred on are those with uncomplicated but severe alcohol dependence and supplementary use of illicit drugs, especially if this

requires prescriptions for controlled drugs. It would be illogical to refer on patients requiring a brief intervention, or patients who are not amenable to treatment. Where there is a dual diagnosis the lead team should be agreed on the basis of what is thought to be the primary psychopathology.

Conclusions

Many doctors are fearful of taking on people with substance misuse problems, perhaps thinking that as patients they will be disruptive. Doctors lacking in therapeutic confidence may find reasons to refer on rather than treat. Addiction teams can help by providing workshops on substance misuse for general psychiatry colleagues as many have done for general practitioners. With a repertoire of skills the challenge of offering a more comprehensive care package for patients becomes less daunting and therapeutic success is certain to follow. With therapeutic success a more rounded approach to training and supervision of medical students and trainees is an inevitable bonus.

Acknowledgements

The understanding dependence section has drawn on the ideas of Gillian Tober and is taken from current work towards her PhD thesis. Thanks are due to Gail Appleyard for expert secretarial support.

References

- Allan, C. A. (1995) Alcohol problems and anxiety disorders – a critical review. *Alcohol and Alcoholism*, **30**, 145–151.
- Ashton, C. H. & Kamali, F. (1995) Personality, lifestyles, alcohol and drug consumption in a sample of British medical students. *Medical Education*, **29**, 187–192.
- Azrin, N. H., Sissons, R. W., Mayer, S. R., *et al* (1982) Alcoholism treatment by disulfiram and community reinforcement therapy. *Journal of Behaviour Therapy and Experimental Psychiatry*, **13**, 105–112.
- Brooke, D. (1995) The addicted doctor. Caring professionals? *British Journal of Psychiatry*, **166**, 149–153.
- Chappel, J. N. (1993) Training of residents and medical students in the diagnosis and treatment of dual diagnosis patients. *Journal of Psychoactive Drugs*, **25**, 293–300.
- Chick, J., Gough, W., Falkowski, W., *et al* (1992) Disulfiram treatment of alcoholism. *British Journal of Psychiatry*, **161**, 84–89.
- Davidson, K. M. & Ritson, E. B. (1993) The relationship between alcohol dependence and depression. *Alcohol and Alcoholism*, **28**, 147–155.
- Edwards, G. (1994) *Alcohol Policy and the Public Good*. Oxford: Oxford University Press.
- & Gross, M. M. (1976) Alcohol dependence: provisional description of a clinical syndrome. *British Medical Journal*, **1**, 1058–1061.
- Heather, N. (1995) Interpreting the evidence on brief interventions for excessive drinkers: the need for caution. *Alcohol and Alcoholism*, **30**, 287–296.

- Kopelman, M. D. (1995) The Korsakoff syndrome. *British Journal of Psychiatry*, **166**, 154–173.
- Kosten, T. R., Rounsaville, J., Babor, T. F., *et al* (1987) Substance use disorder in DSM-III-R: Evidence for the dependence syndrome across different psychoactive substances. *British Journal of Psychiatry*, **151**, 834–843.
- Murphy, G. E. (1992) *Suicide in Alcoholism*. New York: Oxford University Press.
- Orford, J. (1985) *Excessive Appetites*. Chichester: Wiley.
- Penick, E. C., Powell, B. J., Liskow, B. I., *et al* (1988) The stability of coexisting psychiatric syndromes in alcoholic men after one year. *Journal of Studies on Alcohol*, **49**, 395–405.
- Prochaska, J. O. & DiClemente, C. C. (1984) *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Illinois: Dow Jones-Irwin.
- Raistrick, D. S., Bradshaw, J., Tober, G., *et al* (1994) Development of the Leeds Dependence Questionnaire. *Addiction*, **89**, 563–572.
- Ritson, E. B. (1990) Teaching medical students about alcohol. *British Medical Journal*, **30**, 134–135.
- Robertson, I. (1986) A modest statistical phenomenon of little theoretical coherence. *British Journal of Addiction*, **81**, 190–193.
- Room, R. (1989) Drugs, consciousness and self control: popular and medical conceptions. *International Review of Psychiatry*, **1**, 63–70.
- Rounsaville, B. J., Dolinsky, Z. S., Babor, T. E., *et al* (1987) Psychopathology as a predictor of treatment outcome in alcoholics. *Archives of General Psychiatry*, **44**, 505–513.
- Schuckit, M. A. & Monteiro, M. D. (1988) Alcoholism, anxiety and depression. *British Journal of Addiction*, **83**, 1373–1380.
- Thomas, M., Goddard, E., Hickman, M., *et al* (1994) *1992 General Household Survey*. London: HMSO.
- Tober, G. (1991) Motivational interviewing with young people. In *Motivational Interviewing: Preparing People to Change* (eds W. Miller & S. Rollnick), pp. 248–259. New York: Guilford.
- (1992) What is dependence and why is it important? *Clinical Psychology Forum*, **41**, 14–16.
- Volpicelli, J. R., Watson, N. T., King, A. C., *et al* (1995) Effect of naltrexone on alcohol “high” in alcoholics. *American Journal of Psychiatry*, **153**, 613–615.
- Walker, R. (1992) Substance abuse and b-cluster disorders. I. Understanding the dual diagnosis patient. *Journal of Psychoactive Drugs*, **24**, 223–232.
- Young, R. M., Oei, T. P. S. & Knight, R. G. (1990) The tension reduction hypothesis revisited: an alcohol expectancy perspective. *British Journal of Addiction*, **85**, 31–40.
2. *Health of the Nation* targets aim to:
 - a bring everyone into a low-risk drinking level by 2005
 - b bring all women into a low-risk drinking level by 2005
 - c reduce men drinking above low-risk to 18% by 2005
 - d reduce women drinking above low-risk to 7% by 2005
 - e reduce the overall suicide rate by 15% by 2000
 3. Patients with phobic anxiety:
 - a have a diagnosis of alcohol dependence in 50% of cases
 - b drink to relieve anxiety in 50% of cases
 - c do not experience withdrawal symptoms
 - d represent less than 10% of alcohol clinic patients
 - e self-medicate as often with illicit drugs as with alcohol
 4. The action stage of change is recognised by:
 - a positive outcome expectancies
 - b patients’ willingness to do preparation work prior to detoxification
 - c a period of abstinence from alcohol
 - d having skills to effect a behaviour change
 - e having a belief that change is possible
 5. Interventions appropriate to the contemplation stage are:
 - a detoxification
 - b decision matrix
 - c lifestyle change
 - d motivational interviewing
 - e community reinforcement approach

Multiple choice questions

1. The following are markers of substance dependence:
 - a narrowing of drinking repertoire
 - b alcoholic delirium
 - c neuroadaptation
 - d maintaining a constant state (of intoxication)
 - e salience of substance use behaviour

MCQ answers

| | | | | |
|-----|-----|-----|-----|-----|
| 1 | 2 | 3 | 4 | 5 |
| a T | a F | a F | a T | a F |
| b F | b F | b T | b F | b T |
| c F | c T | c F | c F | c F |
| d T | d T | d F | d T | d T |
| e T | e T | e F | e T | e F |